

# Core 400 LLC

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**DATE NOTICE SENT TO ALL PARTIES:** Apr/22/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** lumbar MRI without contrast

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic Surgery

**REVIEW OUTCOME:** Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is this reviewer's opinion that medical necessity for the request for lumbar MRI without contract is not established

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who was injured on xx/xx/xx as a result of lifting at work. The patient is status post L5-S1 posterolateral fusion with instrumentation performed on 12/31/13. The patient had been followed by for continuing complaints of low back pain with left lower extremity numbness that had developed in January of 2015. The patient did report some intermittent right hip pain. The 02/04/15 clinical report noted tenderness to palpation in the lower lumbar paraspinal musculature. There were symmetrical lower extremity reflexes with normal strength and sensation. The patient was recommended for hardware blocks due to tenderness at L5-S1.

The patient did have an MRI of the lumbar spine without contrast completed on 02/10/15 which noted a slight amount of retrolisthesis of L5 on S1. There was a disc extrusion to the right in the paracentral region measuring 1.5cm in length with a transverse diameter of 1cm. There was canal stenosis to 7mm in AP dimension with effacement of the right lateral recess and impression of the descending nerve roots. Mild foraminal narrowing was noted at L5-S1. There was a follow up report by on 03/18/15 which noted the patient had hardware injections with no relief. The patient's physical examination remained unchanged with continued tenderness over the screws at L5-S1. The patient was recommended for L5-S1 hardware removal at this evaluation.

The requested MRI study of the lumbar spine without contrast was denied on 02/10/15 as there was no evidence of significant change on physical examination indicating pathology change at L5-S1 or at adjacent levels to support repeat MRI studies.

The request was again denied on 02/17/15 as there was no evidence of a progressive or new neurological deficit to warrant repeat MRI studies.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been followed for tenderness over the hardware at L5-S1 with no response to hardware injections. The most recent clinical evaluations from noted no motor changes, sensory loss, or new reflex deficits

on physical examination that would support repeat MRI studies of the lumbar spine. Per the current clinical literature, repeat MRI studies are reserved for patients who have significant change of neurological deficit or a sudden new neurological deficit that is unexplained by prior pathology. As this was not clearly indicated in the clinical records provided for review, it is this reviewer's opinion that medical necessity for the request for lumbar MRI without contract is not established at this time and the prior denials are upheld.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)